PIPP Essay

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Personal, Professional and Inter-professional Practice

Nurses and midwives in the United Kingdom have a professional duty of care and must adhere to the standards published within the Nursing Midwifery Council Code (NMC 2015). These standards present the values professionals must uphold and regulations for safe and effective practice. They are supported by evidence based guidelines; in adherence to policy and law, published by the National Institute for Health and Care Excellence (NICE 2016) which are developed within different trusts to form local guidelines. Vryonides et al. (2015) believes that nursing is based on ethical foundations with regards to respecting humanity and an individual's human rights. This signifies the importance of legal frameworks during the delivery of nursing care; legal acts are put in place to protect people; therefore law has a considerable influence on the delivery of care and provision of service. Therefore, incorporation and consideration of the Mental Capacity Act (2005) and the Human Rights Act (1998) is vital during decision making and the planning of care.

This essay will address relevant concerns that may arise during nursing practice with regards to professional, ethical and legal obligations. I will discuss the emerging conflicts in connection with maintaining professional duty and fulfilling what is ethically correct. I am going to consider a patient I met during a practice placement with a Specialist Nurse in a community setting; I will discuss the issues that occurred during the provision and delivery of care for this patient. For the purpose of this essay and to adhere to confidentiality regulations, the patient will be referred to as 'Mrs X' (NMC 2015).

Reflective practice is becoming increasingly valuable within continuous personal development (CPD) (Breadon & McColgan 2012) and is recognised as a way to review individual work and is important when it comes to enhancing performance (Taylor 2000). I will be using the "What? So what? Now what?" Model of Reflection by Boud et al. (1985) in order to identify, analyse and reflect upon this experience with regards to my future as a registered nurse; where I am likely to encounter similar incidents. I believe this model is simple yet effective, presenting clear direction and prompts to guide my reflection.

I met Mrs X during a visit to her home whilst on a practice placement with a Specialist Respiratory Nurse. She was 75 years old had recently been discharged from hospital where she was treated for an exacerbation of her Chronic Obstructive Pulmonary Disease (COPD). On examination, Mrs X's oxygen saturations were 88%, however, no other symptoms were present to suggest a recurrent exacerbation. Mrs X agreed to be assessed for Long-Term Oxygen Therapy (LTOT) and in adherence to NICE guidelines (2016) had two Arterial Blood Gases (ABG's) three weeks apart. Both ABG's confirmed that Mrs X was hypoxic, meaning that she met the criteria for LTOT. The Specialist

Nurse informed Mrs X as to how the oxygen therapy would work in her house, and the positive impact it could have on her life. However, Mrs X decided she did not want the treatment and refused to allow any other arrangements to take place. She understood her COPD would most likely be the primary cause of her death. However, she explained that she was 75 years of age and had decided she did not want to trail any further interventions.

Mrs X was very adamant she would not change her mind and knew exactly what she wanted to do. This resulted in a feeling of helplessness and frustration for my mentor and I, as the therapy could have improved her physical health and possibly had a positive effect on her everyday life. I felt slightly deflated as she had previously responded positively to the idea of LTOT at home and for some reason had now changed her mind.

The refusal of treatment was concerning for us, as research evidence suggests that LTOT can improve a patient's quality of life and increase morbidity (Murphie 2015). Both national and global guidelines advise similar treatment of COPD, therefore, suggesting a robust evidence base recognising the potential benefits. NICE guidance advises LTOT for individuals with COPD and oxygen saturations of less than 90% for 30% of time (2010). The Global Initiative for Chronic Obstructive Lung Disease (GOLD 2016) presents similar findings within the management strategy for patients with COPD around the world. Evidence Based Practice (EBP) assists nurses to make informed clinical decisions which promotes the provision of consistent, safe and effective care (Garland Baird & Miller 2015). It is a nurse's duty to inform and advise patients on treatments based on the best available evidence and encourage shared decision making in relation to their care (NMC 2015). Satterfield et al. (2009) acknowledges the importance of shared-decision making regarding EBP as this takes the patients individual values and beliefs into consideration. Many EBP models have been developed, recognising that research evidence, clinical expertise and patient preference are equally as important when it comes to decision making (Charles et al 2003). Freisen- Storms et al. (2015) acknowledges these aspects and agrees they are fundamental in order to facilitate the decision making process. They also express the importance of support from a skilled nurse to ensure recommendation and understanding of the best available EBP and treatments. The Respiratory Nurse shared her knowledge and educated Mrs X regarding the possible advantages of LTOT and the impact it could have on her life. She also explained that this therapy is recommended for patients in similar situations to her and that research evidence suggests it can be extremely beneficial.

It is crucial that potential risks and benefits of treatments are explained thoroughly to ensure patients are in a position to make an informed decision (Sharp 2015). Decisions made without the provision of expert knowledge can often be made irrationally and can

lead to unexpected outcomes (Eduardo et al. 2015). Difficulties can also occur when patients become overwhelmed with information, therefore, emphasising the importance of effective communication and elimination of medical jargon to ensure patient understanding (Berg et al 2001). Personal preference eventually determined the decision made by Mrs X; which was to refuse LTOT at home. During this time I felt disappointed as I hoped after a thorough explanation of the potential benefits, Mrs X may accept the LTOT. I felt distressed and disappointed as it was likely that her physical condition would deteriorate and her struggle with daily activities increase.

The NMC Code (2015) states that nurses have a professional duty to promote well-being and prevent ill health. However, the right to refuse treatment is an important aspect of care planning. Dempsey (2014) suggests that nurses should listen to patient wishes and support their preferences and decisions. There is therefore distinct conflicts amongst professional standards, however, legislation has the greatest influence in many ethical dilemmas. In England individuals deemed competent have the legal right to refuse medical treatment. This is with reference to The Mental Capacity Act (MCA 2005) and The Human Rights Act (1998) and the components within them.

The Human Rights Act (1998) is related to rights to healthcare, promoting empowerment due to individual entitlement of services and enabling potential benefits (Haigh & Haigh 2007). Personal freedom and autonomy are the primary concepts of the legislation; enabling people to choose how they wish to live their life and how they account for their individual rights (Badzek et al. 2013). Therefore, implying that individuals have the right to refuse health treatment, as they are free to make personal decisions. The standards within the NMC Code (2015) acknowledge that nurses and midwives should respect individual human rights and support patients who decline treatment or care. This highlights the importance of legal frameworks as it ensures nurses promote human rights within their professional role.

The Department of Health (DH 2009) states that individuals with capacity have the right to make an informed decision to refuse treatment. The policy requires health professionals to respect individual rights and support patients' decisions. The MCA (2005) outlines that individuals should always be deemed to have capacity regardless of their age, diagnosis or behaviour. However, when a patient lacks capacity, decision-making is based upon on their best interests (MCA 2005). If Mrs X was considered to lack decision-making capacity the decision may be made on her behalf and LTOT may be implemented to sustain her quality of life. This is a likely situation in these circumstances as the majority of health professionals would argue that LTOT would have a positive impact. However, due to her having sufficient capacity, Mrs X was able to make the decision to refuse this treatment. Research evidence suggest that nurses face many difficulties when a patient refuses treatment that could potentially pro-long their life. It is suggested that nurses may struggle to comprehend and understand why a

patient is making a specific decision which may result in uncomfortable and anxious feelings for them (Griffith 2015a). This is likely to affect their behavior towards the patient, which may compromise the adherence to their professional standards.

I believe I respected Mrs X's autonomous decision to decline LTOT, and understood her reasoning for making that choice. However, I admit feelings of frustration considering the positive impact it could have potentially had. I believe due to the time constrainst of my placements I was not able to form a therapeutic relationship with Mrs X, therefore, believe my support was limited during the decision-making process. I should have employed my core nursing skills to support her during this time (Paganini & Bousso, 2015).

It is vital that patient refusal of treatment is documented accurately. The nurse and I documented the conversation we had with Mrs X and what it entailed. It was vital that we did this to ensure other professionals were able to see the care and discussions we had had about the provision of LTOT. The NMC recognises the importance of record keeping within The Code (2015), expressing that accurate documentation is vital for safe and effective practice, continuity of care and presents as evidence of the delivery of care. Griffith (2015b) argues that documentation of care is as important as the delivery as it provides a clinical history and enables the evaluation of patient progression. He also indicates the legal purposes of records and states they should be detailed and thorough to be regarded as reliable evidence. Patient records can be required as evidence before a court of law or regulatuary body, and a nurses actions are difficult to prove if they are not documented (Reference). Therefore, highlighting the significance of taking time and consideration to include a detailed description of care that is delivered. Once documentation is complete, nurses are accountable for that information, therefore they are responsible if the communication in inaccurate or incomplete (Owen 2005).

Rodden and Bell (2002) argue that the main purpose of patient records is to promote quality care, not to protect nurse accountability. Saranto and Kinnunen (2009) agree that continuity of care should be paramount; they state that documentation is pivotal for effective communication amongst members of the multidisciplinary team. However, McGeehan (2007) suggests that nurses believe documentation is a tedious task and is often completed dismissively at the end of a shift. Cheevakasemsook et al. (2006) states that some nurses consider documentation is becoming more important that the delivery of quality of care, suggesting that nurses may feel they have to choose between providing care and record keeping. Taylor (2003) recognises that inaccurate and incomplete documentation can be a result of its time- consuming nature. He also suggests that nurses' literacy skills and nurse apathy are influencing factors.

This is an extensive issue as the patient should always be the nurse's priority, nurses should use their time to provide the best quality patient care. However if documentation is missed or forgotten there will be serious repercussions for the nurse as they are accountable for their actions (Prideaux 2011). Research evidence shows that there are different purposes for record keeping, and all are extremely important. It is suggested that nurses' attitude and time- constraints are major factors that result in inaccurate documentation. Paans et al (2010) report that implementation of structured documentation and training is valuable for nurses and improves their ability to complete accurate records. A study in Sweden reviewed 343 nurses and their opinion on the effect of structured documentation. They found that 81% of nurses said they believed it improved patient care (Bjorvell et al. 2003). Therefore, suggesting that formal training is a practical way of maintaining effective recordkeeping.

Having spent time with various practitioners, I have seen first-hand the value of documentation, especially within the community setting. It is vital to see what interventions have been implemented in order to monitor patient progression and maintain continuity of care. If the nurse had not documented that Mrs X had refused LTOT, the concept of the patient being offered the intervention would be missing This experience has enforced the importance of record keeping; not only regarding quality of patient care, but also with preference to nurse accountability. If something had happened to Mrs X, it would be our professional duty to ensure we had done all that we could to prevent it. This case clearly emphasises the importance of documentation as the records would have been able to evidence what support have been offered and declined. I was satisfied with the documentation regarding this incident. My mentor composed a through description of what happened and the outcomes of the discussion with Mrs X were made clear.

Beauchamp and Childress (1986) propose a framework, providing four principles to consider regarding ethical issues; respect for autonomy, beneficence, non-maleficence and justice. Respecting individual autonomy is important as it is acknowledges individual values and choice. The principle considers individual rights when determining how they wish to live their lives. Mrs X is able to make the autonomous decision to refuse LTOT as she has capacity and therefore is able to make a decision based upon her values and beliefs with an understanding of any potential consequences (Scanlon 1972). Nurses should endeavour to respect an individual's capacity to make decisions and support the choices they make (NMC 2015). They should provide information to ensure understanding so patients are in a position to make their own decisions (van Thiel & van Delden 2001). The principle of beneficence highlights that nurses should do good, and always attempt to improve patients' health and wellbeing. Non-maleficence promotes that nurses should morally 'do no harm'. This recognises that as healthcare professionals, we are able to do harm, and must always strive to avoid it. Justice refers

to the right to equality and fairness. Nurses should provide care without judgement and be able to justify their actions in every instance (Gillon 1995).

Respecting autonomy empowers patients and places responsibility for any consequences on themselves. If a patient wishes to make such choices, nurses have to allow this, even if it is seen not to be in their best interests Beauchamp and Childress 1986). Autonomy shows to promote patient dignity, therefore, health professionals should respect and support it (Vanov & Oden 2013). The four principles often come into conflict and it becomes difficult to distinguish which dominates in certain situations (Moss 1995). It is often that a health professional's interpretation of beneficence conflicts with a patient's right of autonomy. This is displayed in regards to Mrs X, as the Respiratory Nurse and I believe it would be best for her to have the LTOT, however, she autonomously decided against it. It was important that Mrs X's decision was respected by the nurse and myself. However, I felt uncomfortable as the decision she was making was unlikely to benefit her and had the potential to do harm. This suggests that conflicts also arise between beneficence and non-maleficence and emphasises the consideration of patient's autonomy and legal rights to make individual choices.

Ethical dilemmas present frequently in nursing practice, therefore, it is important to consider the professional, legal and ethical concerns and possible implications. This specific experience has enabled me to reflect on my personal practice and take all aspects into consideration for the future. When Mrs X made the decision not to accept the treatment of LTOT I was shocked and although I understood her rationale, I was disappointed and frustrated when she did not later change her mind. I believe I reacted in this way because I was only considering the potential benefits it could have. Instead, I should have thought about why Mrs X had come to this decision. She had the capacity and understood completely what LTOT entailed, however, still did not want it. Therefore, I should have supported her and the decision she made instead of feeling disappointed, knowing her physical condition was likely to deteriorate without the treatment.

I am likely to encounter similar situations in the future as I proceed to qualify as a registered nurse, and need to learn from these experiences. However, I would hope to be able to form more of a relationship with patients than I had the opportunity to do with Mrs X before supporting them to make such an important decision. I believe I am a reflective learner who strives to learn from my experiences. This particular interaction with Mrs X has had an impact on how I will practice in the future as I continue to support my patients in the decisions they make for their healthcare.

I originally appointed the reflective model by Boud et al (1985) due to its simplistic nature. However, I have found that it lacks context and a model with more components may have assisted me to structure my reflection. I have also found limited research evidence on this model, which provokes me to question its effectiveness. Reflective

practice is valuable for student nurses and registered professionals. It involves the implementation of essential skills such as self-assessment and problem solving (Braine 2009). The NMC recognises the importance of reflective practice with regards to nurse competence and the provision of safe and effective care. The revalidation process is due to commence from April 2016 where nurses are obliged to submit evidence proving their commitment to development, improving practice and their ability to provide care in adhered to the professional standards within The Code (2015).

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